Maturus Software Technologies Corporation
DBA Matutech, Inc
881 Rock Street
New Braunfels, TX 78130
Phone: 800-929-9078
Fax: 800-570-9544

May 31, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Fusion of the right sacroiliac joint with instrumentation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified American Board of Orthopaedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an on-the-job injury that occurred on XX/XX/X. She stated that she was assisting a X with a X who was in a X chair when the injury occurred. She noted that her grip slipped while she was pulling, causing her to "fly across the room hitting the wall and then the floor". She stated that the X she was helping told her that she struck her head on the wall before collapsing onto the floor. The patient attempted to break her fall with her hands. She felt immediate pain and went to the Emergency Room. In addition, she returned to work after the ER visit; however, the pain was so intense that she had to leave after 20 minutes. She was diagnosed with sacroiliitis and internal derangement of the right sacroiliac (SI) joint.

an MRI of the lumbar spine irevealed mild multifactorial degenerative changes present at the L5-S1 level with mild-to-moderate right lateral recess narrowing near contact of the transiting right S1 nerve.

the patient underwent right SI joint injection. Postoperative diagnoses were sacroiliitis and internal derangement of the right SI joint.

XX-XX: Records are unavailable.

XX completed a designated doctor evaluation (DDE) and documented diagnoses of chronic sacroiliitis, lumbar sprain and strain, low back contusion, cervical sprain and strain, left shoulder sprain and strain, left wrist sprain and strain and left wrist contusion. XX opined the patient had reached statutory maximum medical improvement (MMI), and assigned her whole person impairment (WPI) of 19%.

the patient was evaluated for right SI joint and right of midline low back pain radiating down into the right buttock. The pain was aching, burning, stabbing, throbbing, sharp, constant and worsening and rated at 10/10. Associated symptoms included weakness, numbness, tingling, swelling, radiation down the leg and change in bowel/bladder habits. Previous injections had helped temporarily and physical therapy (PT) did not help. Examination revealed an antalgic gait and inability to heel or toe walk. There was tenderness of the posterior superior iliac spine (PSIS) and the SI joint and tenderness of the piriformis. Range of motion (ROM) was painful. Patrick-FABERE test, modified FABER test, thrust test and Fortin's test were positive. Lumbar spine x-rays revealed moderate degenerative disc disease at the L5-S1 level. X-rays of the sacrum and coccyx revealed significant widening of the right SI joint. Diagnosis was right SI joint instability. Surgical treatment was recommended in the form of a fusion of the right SI joint with instrumentation.

XX performed a peer review and denied the request for fusion of the right sacroiliac joint with instrumentation with the following rationale: *"ODG does not support fusion for SI disruption unless there are major pelvic fractures. Guidelines state sacroiliac fusion is recommended on a case-by-case basis as a last line of therapy. The records indicate the claimant has chronic pain with evidence on imaging of degenerative changes of the lumbar spine. The claimant has had prior physical therapy, injection, and oral medication. There is inadequate documentation to support that the claimant's pain is directly related to the sacroiliac joint, based on the records provided. There is no documentation of tumor, sacroiliac joint infection, or specific mechanical instability of the sacroiliac joint, based on the provided records. Sacroiliac arthritis or degenerative sacroiliitis has not been noted. The records reported the claimant had short-term relief with injection, which would support diagnosis; however, objective documentation of the short-term response, such as decreased pain scores, decreased medication use, and/or increased function noted on physical examination findings and progress notes post-injection were not provided, to support the diagnosis. Based on such, the request would not be warranted. The request for fusion of right sacroiliac joint with instrumentation is not certified."*

Per utilization review, XX maintained the requested services were denied.

On XX/XX/XX, XX appealed the adverse determination on behalf of the patient.

Per utilization review XX documented that XX had upheld the denial with the following rationale: *"The previous noncertification by XX was due to lack of documentation of tumor, sacroiliac joint infection, or other specific mechanical instability of the sacroiliac joint. The previous noncertification is supported.*

Additional records were not submitted for review. The records reported that the injured employee had short-term relief with injections, which would support diagnoses; however, objective documentation of the short-term response, such as decreased pain scores, decreased medication use, and/or increase function noted on physical examination findings and progress notes post-injection were not provided to support the diagnoses. The guidelines state that sacroiliac fusion is not recommended for mechanical low back pain, nonspecific low back pain, sacroiliac joint disruption (in the absence of major pelvic fracture), degenerative sacroiliitis, SI joint osteoarthritis, or SI joint mediated pain. As the clinical information submitted for review does not document that the patient has any of the conditions that would warrant an SI joint fusion. Additional clinical information has been submitted for review including office visit from XX/XX/XX, the injured employee was seen for low back and cervical pain, office visit XX/XX/XX the injured employee was seen for sacroiliitis, office visit XX/XX/XX the injured employee was seen for sacroiliitis, and underwent a right Si joint injection. The injured worker was reported to have received tremendous relief in the first few hours following the injection. The block was done with medium acting local anesthetic. Physical therapy notes from SeXX/XX/XX-XX/XX/XX. Medical notes dated February 18, 2016, reported severe 10/10 pain with right lower extremity pain that begins in the right buttock down to the anterolateral thigh down to the foot into the big and second toes. Her right leg has been turning outwards and she is unable to use a cane for stability. Lying down causes severe pain. These symptoms will not be alleviated by a sacroiliac fusion. Under these circumstances a sacroiliac fusion does not seem to be a prudent decision and the request should not be certified."

the patient was evaluated for follow-up. She had concerns of her legs and feet swelling and increasing in her pain. The request for right SI joint fusion had been submitted in XX and was denied. The patient stated she went to court in XX/XXXX and had won her case, so her doctor recommended that she return to XX office to resubmit for surgery. The patient reported increased urinary frequency and incomplete emptying. She reported muscle aches, arthralgias, SI joint pain and back pain as well as weakness, numbness and sleep disturbances. Examination revealed an antalgic gait and inability to heel or toe walk. There was tenderness of the posterior superior iliac spine (PSIS) and the SI joint and tenderness of the piriformis. Range of motion (ROM) was painful with flexion 20 degrees and extension 5 degrees. Patrick-FABERE test, modified FABER test, thrust test and Fortin's test were positive. Diagnoses were SI joint instability and inflamed SI joint. She was given a Toradol injection and prescribed cyclobenzaprine, ibuprofen, Norco and ketorolac.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The requested right sacroiliac joint effusion still fails to meet guidelines for the procedure. This patient appears to have pain in the region of the sacroiliac joint and some pain with provocative testing. However, the patient has multiple confounding factors of lower back pain, muscle aches, legs and feet swelling, weakness and numbness. The patient has significant lumbar spine pathology by prior MRI in XXXX. The patient has a history of what appears to be radicular pain. It's not clear that the majority of the patient's symptoms are truly related to the sacroiliac joint even though the patient had some transient relief after previous sacroiliac joint injection. It is highly likely that this patient would still have significant ongoing issues even in the presence of a successful sacroiliac joint fusion. Guidelines specifically state that patients would not be recommended for a sacroiliac joint fusion in the presence of back pain from other causes or

even a sacroiliac joint disruption in the absence of major pelvic fracture. The patient's distal extremity complaints would not be expected to improve with a sacroiliac joint fusion. It is not clear if the patient has undergone any updated imaging of the lumbar spine to determine if this is contributing to the patient's lower extremity symptoms. For all of these reasons, a sacroiliac joint fusion would not seem prudent or medically indicated at this time based on the information reviewed as well as current guidelines regarding the procedure.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (21st annual edition) 2016
Chapter Hip & Pelvis (updated 05/02/16)
Criteria for Sacroiliac fusion:

(A) Recommended on a case by case basis as a last line of therapy as treatment for the following conditions with ongoing symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated, e.g. severe traumatic injury):

(1) Sacroiliac joint infection;

(2) Tumor involving the sacrum;

(3) Disabling pain due to sacroiliitis due to spondyloarthropathy;

(4) Sacroiliac pain due to severe traumatic injury;

(5) In conjunction with multisegmental spinal constructs (i.e., scoliosis or kyphosis surgery).

(B) Not recommended for the following conditions:

(1) Mechanical low back pain;

(2) Non-specific low back pain;

(3) Sacroiliac joint disruption (in the absence of major pelvic fracture);

(4) Degenerative sacroiliitis;

(5) SI joint osteoarthritis;

(6) SI joint mediated pain.

(C) May be either open or minimally invasive (percutaneous).

Official Disability Guidelines (21st annual edition) 2016
Chapter Hip & Pelvis (updated 05/02/16)
Indications for imaging -- Magnetic resonance imaging:

Osseous, articular or soft-tissue abnormalities

Osteonecrosis

Occult acute and stress fracture

Acute and chronic soft-tissue injuries

Tumors

Exceptions for MRI

Suspected osteoid osteoma (See CT)

Labral tears (use MR arthrography unless optimized hip protocol and MRI with 3.0-T magnets)

Official Disability Guidelines (21st annual edition) 2016
Chapter Hip & Pelvis (updated 05/02/16)
X-Ray
Recommended. Plain radiographs (X-Rays) of the pelvis should routinely be obtained in patients sustaining a severe injury. (Mullis, 2006) X-Rays are also valuable for identifying patients with a high risk of the development of hip osteoarthritis. (Gossec, 2009) (Reijman, 2005) (Conrozier, 2001) Although the diagnostic performance of the imaging techniques (plain radiography, arthrography, and bone scontigraphy) was not significantly different, plain radiography and bone scintigraphy are preferred for the assessment of a femoral component because of their efficacy and lower risk of patient morbidity. (Temmerman, 2005) X-rays are not as sensitive as CT in detection of subchondral fractures in osteonecrosis of the femoral head. (Stevens, 2003) (Stumpe, 2004)

Plain radiographs are usually sufficient for diagnosis of hip fracture as they are at least 90% sensitive. Standard radiographic hip imaging includes antero-posterior (AP) pelvic projection with dedicated AP and cross-table lateral projections of the affected hip. Conventional estimates have put the sensitivity of these projections for hip fracture between 90% and 98%. (Cannon, 2009) This study highlights the limitations of radiography in detecting hip or pelvic pathologic findings, including fractures, as well as soft-tissue pathologic findings. MRI shows superior sensitivity in detecting hip and pelvic fractures over plain film radiography. (Kirby, 2010)

Official Disability Guidelines (21st annual edition) 2016
Chapter Hip & Pelvis (updated 05/02/16)
Intra-articular steroid hip injection (IASHI)
Not recommended in early hip osteoarthritis (OA). Under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Recommended as an option for short-term pain relief in hip trochanteric bursitis. (Brinks, 2011) Intraarticular glucocorticoid injection with or without elimination of weight-bearing does not reduce the need for total hip arthroplasty in patients with rapidly destructive hip osteoarthritis. (Villoutreix, 2005) A survey of expert opinions showed that substantial numbers of surgeons felt that IASHI was not therapeutically helpful, may accelerate arthritis progression or may cause increased infectious complications after subsequent total hip arthroplasty. (Kasper, 2005)

Historically, using steroids to treat hip OA did not seem to work very well, at least not as well as in the knee. However, the hip joint is one of the most difficult joints in the body to inject accurately, and entry of the therapeutic agent into the synovial space cannot be ensured without fluoroscopic guidance. Fluoroscopically guided steroid injection may be effective. (Lambert, 2007) Corticosteroid injections are effective for greater trochanteric pain syndrome (GTPS) managed in primary care, according to a recent RCT. GTPS, also known as trochanteric bursitis, is a common cause of hip pain. In this first randomized controlled trial assessing the effectiveness of corticosteroid injections vs usual care in GTPS, a clinically relevant effect was shown at a 3-month follow-up visit for recovery and for pain at rest and with activity, but at a 12-month follow-up visit, the differences in outcome were no longer present. (Brinks, 2011) See also Sacroiliac joint blocks; Sacroiliac joint radiofrequency neurotomy; Trochanteric bursitis injections; & Intra-articular growth hormone (IAGH) injection.